

**MINUTES OF THE
BOARD OF COMMUNITY HEALTH MEETING
November 8, 2007**

Members Present

Richard Holmes, Chairman
Ross Mason, Vice Chairman (via phone)
Mark Oshnock, Secretary
Dr. Inman “Buddy” English
Kim Gay
Frank Jones
Richard Robinson
Dr. Ann McKee Parker

Members Absent

The Board of Community Health held its regularly scheduled monthly meeting in the Floyd Room, 20th Floor, West Tower, Twin Towers Building, 200 Piedmont Avenue, Atlanta, Georgia. Commissioner Rhonda Meadows was present. (An Agenda and a list of Attendees are attached hereto and made official parts of these Minutes as Attachments #1 and #2).

Chairman Holmes called the meeting to order at 9:14 a.m.

Jared Duzan and Beverly Dilley of Myers and Stauffer began with an update on the Care Management Organization (CMO) Audit Initiative. Mr. Duzan reviewed the work plan.

Task 1, Hospital Concerns and Issues, is Myers and Stauffer’s exploration of the issues and concerns expressed by hospitals. Myers and Stauffer started the task in late September with hospital industry groups and individual providers and discussed and documented specific concerns and issues, reviewed documentation from those providers, compiled information and selected some hospitals and issues for verification. Myers and Stauffer have begun holding individual meetings with many of those hospitals and CMOs to discuss the issues and concerns. Mr. Duzan said he felt the meetings were productive and some of the issues that were expressed at the end of September have begun to be resolved. Myers and Stauffer categorized the issues into three compartments:

1. Issues currently being addressed by the audit – some of the more prevalent issues expressed were emergency room claims payment, payments not in accordance with contractual agreements, timeliness edits, and contract loading and credentialing.
2. Subsequent issues – issues that Myers and Stauffer will be reviewing that have high priority but not the highest of priorities.
3. Issues expressed to Myers and Stauffer by hospitals but are being addressed by the Department – in some cases these issues are already being worked, have been examined or are planned to be addressed in the future.

Mr. Oshnock asked if any of the analysis thus far surprised Mr. Duzan based on his initial discussion with DCH. Mr. Duzan said this was a pretty close match to the issues expressed by the Department. The comments from the hospitals very closely overlapped with what the Department described. Mr. Duzan said Myers and Stauffer will issue a report of the findings on Task 1 approximately December 28, 2007. Dr. English asked if Myers and Stauffer will explore issues outside of hospital provider groups. Mr. Duzan said that is the plan to address other categories but that decision would be made by the Department. Mr. Jones asked if Myers and Stauffer was soliciting comments. Mr. Duzan said they did not randomly select hospitals and contact them; rather they met with each of the major hospital associations and they were able to bring hospital providers to those meetings, and then following those meetings, the hospital could submit verifiable data and information to Myers and Stauffer.

Task 2, Claims Analysis, is the analytical phase of the audit where Myers and Stauffer will be examining claims payments. Mr. Duzan said there has not been a lot of progress in this phase as of yet because they are gathering the data and information from the CMOs. Next steps are: receive data and information request from CMOs, review data and information and submit any follow up request to the CMOs, load and prepare for analysis, perform analysis of CMO data and information and report findings. Mr. Duzan said he expects to have the report on those findings of Task 2 in mid-March.

Task 3, CMO Policies and Procedures, is the review of some CMO policies and procedures and make comparisons to industry standards, particularly other state Medicaid managed care programs. Myers and Stauffer expects to have a report on Task 3 findings in April. Mr. Duzan concluded his report after addressing comments and questions from the board.

Chairman Holmes acknowledged that he had skipped the approval of the Minutes. The Minutes of the October 11 Meeting were UNANIMOUSLY APPROVED AND ADOPTED.

Department Updates

Mr. Clyde Reese, Executive Director, Health Planning Division, said these set of rules were originally proposed and approved for initial adoption at the September meeting. A public hearing was held on the proposed changes on October 29. Rule 111-2-2-.33 (Specific Review Considerations for Continuing Care Retirement Community (CCRC) Sheltered Nursing Facilities) clarifies that a CCRC review for sheltered nursing facility beds would not be required to be reviewed under the Nursing and Intermediate Care Facilities rules. Only one oral comment was made at the public hearing in support of the changes. Rule 111-2-2-.07 (Review Procedures) expands the definition of emergency expenditures and clarifies the process by which the Department will approve an emergency expenditure. Rule 111-2-2-.34 (Specific Review Considerations for Traumatic Brain Injury Facilities) defines how an applicant for a new or expanded traumatic brain injury program will demonstrate need. Rule 111-2-2-.09 (General Review Considerations) is a recitation of the statutory considerations that are applicable to all CON applications. It clarifies the Department's process for assessing how the applicant will ensure quality services as measured by certain quality standards; adds language to allow the Department to give special consideration to CON applications wherein the applicant is a hospital/physician joint venture; and allows the Department to give priority consideration to CON applications that lend to the provision of services that are or have been underrepresented in the proposed service area in the previous 12 months. Secretary Oshnock MADE a MOTION to approve for final adoption Rules 111-2-2-.33, .07, .34 and .09. Mr. Jones SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (Copies of Rules 111-2-2-.33, .07, .34 and .09 are hereto attached and made an official part of these Minutes as Attachments 3, 4, 5 and 6).

Carie Summers, Chief Financial Officer, presented for final approval two public notices: the Mental Retardation Waiver Program Community Habilitation and Support Services Public Notice and the Disproportionate Share Hospital Payments Public Notice. The rate increase for Mental Retardation Waiver Program Community Habilitation and Support Services is specific to support coordination services. This 9.5% increase is supported by appropriations made available by the General Assembly in the FY 2008 budget and will increase the Per Member Per Month from \$136.88 to \$149.88. The additional dollars to cover this increase are \$4.4 million total funds and almost \$1.9 million state funds. No one testified at the October 25 hearing nor was any written comment received. Secretary Oshnock MADE a MOTION to approve the Mental Retardation Waiver Program and Community Habilitation and Support Services Public Notice. Dr. Parker SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION WAS UNANIMOUSLY APPROVED. (A copy of the Mental Retardation Waiver Program and Community Habilitation and Support Services Public Notice is attached hereto and made an official part of these Minutes as Attachment # 7).

Ms. Summers moved on to the DSH Payments Public Notice. She said the Department received several written comments and oral comments at the October 25 hearing. Ms. Summers reminded the board of the goals of the DSH reform that the Department is proposing as a part of this public notice and the considerable amount of work that was done by both the Hospital Advisory Committee and DSH Subcommittee. The goals of DSH reform in FY 2008 are twofold: considering changes that direct DSH funds to hospitals most impacted by uncompensated Medicaid and uninsured costs, and recognize that hospitals rely on DSH as a Medicaid subsidy, even if they are not the most disproportionate. She reviewed the seven guiding principles that the Hospital Advisory Committee agreed upon and asked the board to focus on three of them as they consider some of the comments received:

Guiding Principle 1 – DSH payments should be directed in proportion to uncompensated care provided. She said some of the comments received suggested that the Department is not doing that. She said the way the Department has adjusted the methodology to recognize those who are most disproportionate get a larger percent of the DSH funds available complies with that principle.

Guiding Principle 7 – eligibility criteria should be reconsidered. Until FY 2007 hospitals had to meet both federal criteria and one of nine state criteria. Eligibility criteria had not changed since the 1990s. Some comments received suggested that the Department should continue with the existing criteria or further narrow the criteria to have fewer hospitals eligible for the funds.

Guiding Principle 6 – Changes in DSH payments should not put an undue burden on any hospital group. She said this goes back to the second goal of recognizing that hospitals rely on DSH funds, and the Department must be considerate of that goal as they consider any proposed changes.

Mr. Oshnock asked when the Guiding Principles were developed. Ms. Summers said the Guiding Principles were agreed upon by the Hospital Advisory Committee in July 2007 and were provided to the DSH Subcommittee who met numerous times. The DSH Subcommittee was unable to unanimously agree on a model. In an effort to wrap up and bring a recommendation to the Board on how the Department should move forward, the Department gave the HAC a series of nine questions. She reviewed the order of discussion of questions and the HAC vote outcome. She briefly reviewed the public notice bringing to the board's attention eligibility (federal criteria) and allocation methodology. Ms. Summers also summarized the written comments received. Secretary Oshnock asked for consideration of new hospitals that did not have FY 05 data that would keep them from being considered for a DSH payment. Ms. Summers said the Department would be willing to review, however the new hospitals would be subject to the 10% limit. Mr. Jones MADE a MOTION to approve the Disproportionate Share Hospital Payments Public Notice. Dr. Parker SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of the Disproportionate Share Hospital Payments Public Notice is hereto attached and made an official part of these Minutes as Attachment # 8).

Mr. Holmes called for a 10-minute recess. After the recess, Chairman Holmes asked Nancy Goldstein, Chief, State Health Benefit Plan, to give an overview of the SHBP Strategy. There are 17 plan options: a PPO, four HMOs, indemnity, a High Deductible Health Plan, two health reimbursement accounts (pilots), a Tricare Supplement, and a consumer choice option for each plan. The SHBP covers 680,000 members—340,000

employees and retirees. Ms. Goldstein said the current health care costs will be \$2.69 billion in 2008 and could total \$16.9 billion in the next five years (if there was no change in strategy). The SHBP baseline assumed growth rates are 11.5 percent per year (two percent assumed membership growth rate) and 9.3 percent per year per capita (no assumed membership growth rate). On a per capita basis the current expenditures are \$7,751 per employee/retiree per year in 2008.

The mission of the SHBP Five-year Strategic Plan is to develop a five-year health care strategy with consumer driven health care and consumerism as a key part of the strategy. The objectives are to promote consumerism; meet financial target (of the state revenue growth which is about 7%), provide meaningful member choice through streamlining options, and opportunity for long term success. Ms. Goldstein discussed the advantages of consumer driven health plans and explained how health reimbursement accounts work. Health Program objectives are to reduce the annual cost increases two percentage points less than the baseline; reduce the GASB (OPEB) liability; add consumerism and consumer driven health care; encourage utilization of health promotion and health coaching (disease management) programs; maintain employee satisfaction and appreciation; and be competitive with other larger employers.

The High Level Strategy (2008-2012) is to provide two statewide health plan vendors—each offering five choices: HRA (CDH Plan), HDHP (CDH Plan), PPO, HMO, and Medicare Advantage; integrate pharmacy benefits with medical benefits; improve the CDH plan design each year; add consumerism features such as deductibles and coinsurance to the HMO and PPO each year; utilize strategic pricing to provide incentive for CDH plans; and expect gradual enrollment shift from HMO/PPO plans to HRA and HDHP plans. Ms. Goldstein reviewed the tactical steps year-by-year. In 2008 the SHBP will expand two HRA plans statewide, eliminate one HMO, freeze Indemnity plan enrollment, eliminate Tricare Supplement (due to federal legislation), release health plan vendor RFP for consolidation, and continue communications on HRA or HDHP plans. In 2009 the SHBP will consolidate to two health plan vendors statewide, eliminate one HMO, eliminate indemnity plan, improve HRA plan and HDHP plan design, introduce three or four tier employee contributions and continue consumerism education. During the next three years, 2010-2012, the SHBP will continue the strategy of increasing CDH enrollment.

Ms. Goldstein reviewed the estimated five-year savings. She said the big savings will begin in 2009 once the SHBP consolidates vendors and more members enroll in the consumerism plans. The estimated five-year savings is over \$835 million. After addressing questions from the Board, Ms. Goldstein concluded her report. (A copy of the State Health Benefit Plan Strategy is hereto attached and made an official part of these minutes as Attachment # 9).

Chairman Holmes asked Kathy Driggers, Chief, Managed Care and Quality, to talk about the Georgia Families Quality Strategic Plan and a Request for Required Public Input. He then asked Secretary Oshnock to preside as he had to leave the meeting. Ms. Driggers said Section 1932 of the Social Security Act sets forth specifications for Quality Assessment and Performance Improvement strategies that States must implement to ensure the delivery of quality health care by all managed care organizations. The purpose of the Strategic Plan is an explanation of how the state will assess the quality of care delivered through the CMOs and how the state, based on this assessment, will improve the quality of care delivered through the CMO. The Centers for Medicare and Medicaid Services expects the written quality strategies of each state to provide an introduction/overview of the managed care program, assess quality and appropriateness of care and service delivery, level of contract and regulatory compliance of the CMOs, and the level of impact that health information technology changes/evolution on the program. CMS also expects states to share interventions planned to improve the quality of care and describe the frequency of assessments of strategy performance, frequency of report strategy update to CMS, and a summary of evaluation methods and performance targets. Federal Regulations require the DCH to request public input and make the Georgia Quality Assessment and Performance Improvement Strategy available for public comment before final adoption. The Department will bring comments back to the board at the December board meeting to ask for final approval of the strategy. (A copy of the Request for Required Public Input is hereto attached and made an official part of these Minutes as Attachment # 10).

Commissioner's Comments

Secretary Oshnock asked Dr. Meadows to give the Commissioner's comments. Dr. Meadows said the SCHIP is in the final days of the current short-term extension. Authorization and funding for the program ends November 16. She said there have been rumors about program extensions, but more important than the timing of the extension is that the extension must contain appropriate levels of funding; otherwise, Georgia will be in another shortfall again.

Dr. Meadows said the SHBP is in the final days of Open Enrollment and encouraged all state employees to quickly complete their Open Enrollment packet.

Finally, she reported that the Department announced this week the winners of the Health Information Exchange pilot program. Four partnerships received grant funding for what the Department hopes to be seed money to encourage them to develop electronic medical records, e-prescribing and health information exchange bases.

Adjournment

There being no further business to be brought before the Board, Secretary Oshnock adjourned the meeting at 11:35 a.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE _____ DAY OF _____, 2007.

RICHARD L. HOLMES
Chairman

ATTEST TO:

MARK D. OSHNOCK
Secretary

Official Attachments:

- #1 List of Attendees
- #2 Agenda
- #3 CON Rule 111-2-2-.33
- #4 CON Rule 111-2-2-.07
- #5 CON Rule 111-2-2-.34
- #6 CON Rule 111-2-2-.09
- #7 MRWP/CHSS Public Notice
- #8 DSH Payments Public Notice
- #9 SHBP Plan Strategy
- #10 Request for Required Public Input